REVISED 2/28

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

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Chief of Staff

February 15, 2008

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Waxman:

As requested by the Committee, the NYS Department of Health has prepared the enclosed information relevant to the six Centers for Medicare and Medicaid Services (CMS) regulations released over the past year as identified in your letter dated January 16, 2008.

Please be advised, as this information is studied, that the fiscal impacts of the proposed regulations are in some instances partially overlapping because they have similar negative impacts on programs. Because of the potentially devastating results these actions could create, it is imperative that the potential impact of each individual regulation be separately presented. It also bears mentioning that some aspects of these regulations could potentially lead to an increase in Medicaid costs by creating incentives for more costly acute care services.

We hope that this information and analysis of these specific CMS proposals is helpful in determining the immediate and long-term effects of these ill-conceived proposals. If you have further questions, please contact me at (518) 474-3018.

Sincerely,

Deborah Bachrach DT

Deborah Bachrach
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosure

cc: Tom Davis
Ranking Minority Member

CMS REGULATORY ACTIONS: NEW YORK STATE IMPACT

RECENT CMS ACTIONS

The Centers for Medicare and Medicaid Services (CMS) has embarked on a series of administrative actions that shift costs from the federal government to the States and drastically reduce federal funding for critical Medicaid providers, including state agencies, local governments, teaching hospitals, and school districts.

The proposed and threatened administrative actions are a substantial departure from past practices and reflect new and unsupported interpretations in Medicaid law. Almost all of the statutory provisions that CMS is "clarifying" have been in place for at least 15 years and some have been part of Title XIX since the inception of Medicaid in 1965.

CMS recently evaded Congress's attempt to place a moratorium on some of its proposals by sending the new rules to be finalized just hours before the moratorium was signed into law, rendering the moratorium all but moot. ***Since then, CMS has promulgated several rules that are the opposite of expressed Congressional intent – and which violate both statute and moratoriums already in place.***

RULES PUBLISHED BY CMS

The CMS proposals that will shift costs to the States and reduce Medicaid funding are summarized below, along with the effect these proposals will have on New York.

1. Provider Tax Regulations

On March 23, 2007, CMS proposed changes to the rules that regulate state taxation of healthcare related entities. The current rules were put in place in 1992, after extensive negotiations between states and the federal government, to establish clear-cut rules governing the types of taxes that could be collected by states from health care providers.

The proposal issued in March would essentially undo the current framework by allowing CMS to deem any tax impermissible based on a subjective determination that there is a "linkage" between the tax and Medicaid or non-Medicaid payments. If a tax is found impermissible, CMS reduces federal Medicaid funding to the State by fifty percent of the entire amount collected from the tax, regardless of whether any portion of the tax is actually reimbursed by Medicaid with a federal share.

Impact on New York State

New York has a number of provider taxes, including taxes on nursing facilities and hospitals. The vagueness and subjectivity of the new rule means that there is no absolute assurance that New York's taxes are protected. If New York's taxes are deemed impermissible under the proposed rule, the State could suffer up to hundreds of millions of dollars in disallowances of federal Medicaid funding annually. This would affect funding for uninsured and underinsured individuals served by Child Health Plus, Family Health Plus, Healthy NY and the Elderly Pharmaceutical Insurance Programs. Other vulnerable populations receiving support from these revenue sources include those infected with HIV/AIDS, those suffering from cancer, and individuals with mental health and developmental disabilities.

2. Outpatient Hospitals and Clinic

On September 28th, CMS published a rule that redefines what Medicaid can reimburse under the hospital outpatient benefit to include only those services Medicare reimburses through its more restrictive definition of outpatient hospital services. Hospitals would not be reimbursed under the hospital outpatient benefit for such things as: hospital based physician services; routine vision services; annual checkups; vaccinations; school-based services; and rehabilitation services. Note: Many of these services may still be reimbursable under Medicaid if provided under a different category of service.

CMS also redefines how States must calculate Medicaid upper payment limits (UPLs) for hospital outpatient and non-hospital clinic services. UPLs establish the maximum amount Medicaid can pay for these services. CMS's proposed UPL methodology is highly restrictive and administratively burdensome. CMS proposes to require the State to calculate UPLs for hospital outpatient services based on specific Medicare cost report worksheets that do not reflect graduate medical education costs of teaching hospitals or costs of many other services provided in New York's hospitals, such as physician services. Additionally, CMS proposes that the UPL calculation for non-hospital clinic services be based on Medicare fee schedules, which also do not recognize many of the unique costs and services provided by NYS community-based providers.

The above described service and UPL driven payment restrictions would not only damage the current outpatient and clinic health care delivery systems in New York, but would also create obstacles to the State's ambitious primary care agenda. The State is embarking on a major initiative to reform and enhance its outpatient delivery system and provide greater access to primary and preventive care, which will ultimately result in cost efficiencies and improved health outcomes in the State's overall Medicaid program. New York's heath care reform goals will be far more difficult to achieve, if this regulation is not stopped.

Impact on New York State

NYS Medicaid spending is nearly $2.1 billion annually for hospital outpatient and non-hospital clinic services, of which nearly $1.2 billion is for mental health, developmental disability and substance abuse services. While it is difficult to determine the exact fiscal impact of this regulation on New York's health care delivery system, we anticipate that there would be a significant loss of federal Medicaid funding. Worse yet, absent Congressional action or litigation, CMS may attempt to apply aspects of the regulation retroactively. Further, the rule violates the Congressionally enacted moratorium that precludes CMS from implementing regulations that change Medicaid financing practices or eliminating Medicaid GME funding. The changed definition of hospital outpatient services could also impact the amount that can be paid under the Medicaid disproportionate share hospital program, which subsidizes hospitals for indigent care services.

3. Targeted Case Management

On December 4, 2007, CMS published an interim final rule regarding optional case management and targeted case management (TCM) services. The regulation will become effective on March 3, 2008. This regulation, in part, implements Section 6052 of the Deficit Reduction Act (DRA); however, it goes beyond what was authorized in the DRA. In addition, there is an inherent contradiction with the Ryan White statute.

This rule would reduce the number of days an individual can receive TCM services, prohibit payment for transitional case management services provided to inpatients being discharged until an individual is in the community, limit state flexibility to manage the Medicaid program and require providers to bill in increments of 15 minutes of less (not part of DRA). Further, this proposal would restrict funding for New York's Bridges to Health (B2H) waiver for foster children, which was approved in 2006.

Impact on New York State

New York has a number of case management programs including but not limited to: 1) early intervention (EI) services for infants and toddlers with disabilities; 2) school-based health services for students with disabilities; 3) teenage services pregnant or parenting adolescents; 4) AIDS follow-up programs; 5) intensive case, supportive case and blended and flexible case management services; and 6) other Medicaid programs that provide necessary medical, social, educational, psychosocial, employment, habilitation, rehabilitation and residential and legal support in accordance with the person's individualized service plan. While our analysis of the fiscal impacts associated with this regulation is still a work in progress, we anticipate that New York State providers stand to lose substantial amounts of federal Medicaid funding. For more detailed information on the negative programmatic impacts associated with this regulation, enclosed are letters sent to CMS by four State Agencies.

4. Cost-Limit for Government Providers and Financing Restrictions on Sources of Federal Share

On January 18, 2007, CMS published a proposed rule that would: 1) limit Medicaid payments to governmentally-operated providers to cost; 2) require all governmentally-operated facilities to report their costs annually; and 3) narrow the definition of a "governmentally-operated" provider to those with taxing authority or that are part of a unit of government that has such authority (which, in effect, would reduce the sources of funding that can be used as the non-federal share of Medicaid expenditures).

Recognizing that the new rules represent a significant departure from longstanding practice, Congress included a moratorium on the finalization or implementation of this rule in the supplemental appropriations for Iraq war funding. Because CMS sent the rule for publication just hours before the 1-year moratorium went into effect, providers are forced to prepare now for the rule that will take effect when the moratorium ends in May 2008. Thus, with just the 1-year of protection, the moratorium does not protect the status quo, as Congress intended.

Impact on New York State

New York State providers could lose in excess of $550 million of federal Medicaid funding if this new rule takes effect. The losses would have particular negative consequences on the NYC Health and Hospital Corporation, services for the mentally ill, early intervention programs and New York's nationally recognized service system for the mentally retarded and developmentally disabled. This rule would reduce incentives public providers now have to keep costs below payment rates so they have excess funds to offset the costs of providing services to the indigent and uninsured. The rule would impose impossible administrative burdens on New York, such as complex, site-specific cost reports for school districts and over 1200 small group homes for persons with disabilities, and surveys of thousands of school districts and hundreds of nursing homes and hospitals to determine it they are "governmentally-operated".

5. Elimination of Medicaid Reimbursement for Graduate Medical Education

On May 23, 2007, CMS published a proposed rule that would eliminate Medicaid funding for graduate medical education (GME). Almost all state Medicaid programs have reimbursement rates that pay for a proportionate share of a teaching hospital's GME costs, as does Medicare. The proposed rule now "clarifies" that costs and payments associated with GME programs are not expenditures for medical assistance for which federal reimbursement is available.

The unjustified prohibition of these costs as Medicaid reimbursable will substantially reduce payments to the nation's teaching hospitals, which tend to be the most critical providers of hospital care for Medicaid and other indigent patients.

Impact on New York State

Eliminating Medicaid funding for GME would have a devastating impact on New York's GME programs, and would result in an estimated loss of $675 million in federal funding annually. New York has been a leader in this area, training 15 percent of the nation's physicians. CMS' action would severely penalize New York for being steadfast in its commitment to maintain the public good.

6. Rehabilitation rule

On August 13th, CMS published a rule that makes significant changes to the definition and financing of Medicaid rehabilitation services. It seeks to create a firm distinction between rehabilitation services and habilitation services, which must be paid for by other programs. However, as proposed, this delineation does not adequately account for the complex nature and scope of these necessary services. States have made tremendous progress in designing programs to address the needs of Medicaid enrollees in developing and reviewing their plan of care, when appropriate.

The proposed rule requires that a "qualified provider" deliver rehabilitation services. Qualified providers are defined as individuals, rather than programs. This is a departure from the State's current approach, which views a "qualified provider" to be a licensed agency, rather than the staff members employed by the program.

Impact on New York State

The rehabilitation rule could jeopardize up to $45 million in annual federal funding for the Early Intervention program that provides services to children under age three with developmental disabilities or delays, and for many of New York's programs for persons with mental illness, including housing-related supports and services, employment-related supports and services, services that use a team-based approach, and any program that includes another type of treatment goal, such as a social skills development goal. In the mental health and developmental disability areas alone, up to $113 million in annual federal revenues could also be jeopardized. Lastly, $44 million in annual federal Medicaid reimbursement could be jeopardized for school-based services administered through Department of Education, local school districts and nonprofit providers.

7. School Based Health Services

On September 7th, CMS issued a proposed rule that would eliminate Medicaid funding for school based administration expenditures and costs related to transportation of school-age children between and home and school. Under the proposed rule, CMS would eliminate a longstanding policy of providing federal matching payments for administrative activities when performed by school employees or contractors and for transportation services between home and school for school-aged children with an Individualized Education Program (IEP) or an Individualized Family Services Plan (IFSP) under the Individuals with Disabilities Act (IDEA).

The proposed rule would also eliminate federal reimbursement for expenditures for transportation between home and school for children with an IEP or IFSP established pursuant to IDEA. This proposal is based on the HHS Secretary's determination that transportation between home and school does not meet the definition of an optional medical transportation service and is not necessary for the proper and efficient administration of the state plan.

Impact on New York State

The proposed rule would eliminate all funding for transportation between home and school for school-aged children with an Individualized Education Program ("IEP") under IDEA. Transportation still remains available between school or home to a non-school based medical service provider, yet if the Medicaid covered medical service is being offered at school, then transportation reimbursement is not available. Additionally, federal funding remains available for the transportation of all other groups of Medicaid-covered individuals to medical service providers. It is only school-aged children receiving medical services at school whose transportation will not receive federal funding. This funding expectation violates federal regulations that require comparability in the amount, duration, and scope of services for all those who quality for Medicaid services. New York State would lose $44 million annually in transportation funding. The state does not claim administration costs.

New York State
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Family
Services

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February 1, 2008

Mark B. McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-2237-IFC: Interim Final Rule: Medicaid Program: Optional State Plan Case Management Services

Dear Dr. McClellan:

This responds to the Interim Final Rule published in the December 4, 2007 Federal Register (72 FR 68077-68093) by the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) to incorporate changes made by section 6052 of the Deficit Reduction Act of 2005 (DRA), the Consolidated Omnibus Budget Reconciliation Act of 1985, the Omnibus Budget Reconciliation Act of 1986, the Tax Reform Act of 1986, the Omnibus Budget Reconciliation Act of 1987, and the Technical and Miscellaneous Revenue Act of 1988, concerning case management services.

The New York State Office of Children and Family Services (OCFS) writes to express its concern regarding the interpretation, and objection to the application of the provisions of the Interim Final Rule and any final rule to programs operating pursuant to §1915 of the Social Security Act Home and Community Based Service waivers from CMS. We assert that Home and Community Based (HCBS) waivers should be excluded from this rulemaking because:

- HCBS waivers are individually negotiated between CMS and a state;
- HCBS waivers are cost neutral and intended to benefit a mutual constituency; and
- HCBS waivers are outside the scope of the DRA.

CMS approved the Bridges to Health (B2H) Home and Community Based Services Waiver applications on July 19, 2007. The B2H Waiver Program, operated by OCFS, became effective on January 1, 2008. The B2H Waiver Program services are specifically tailored to support the health and well-being of children in foster care with serious emotional disturbances, developmental disabilities and/or medical fragility.

Authorized under §1915(c) of the Social Security Act, and designed pursuant to §366(12) of the New York State Social Services Law, the B2H Waiver Program permits OCFS to furnish an array of home and community-based services that assist Medicaid- eligible individuals to live in the community and avoid medical institutionalization. The intent of the B2H Waiver Program is to provide community based support of health care services to a limited number of children in foster care at less cost than would be incurred if these children were to be placed or remain in a residential treatment facility, hospital or institution. B2H services are provided in the least restrictive, most integrated setting. The services provided through the B2H Waiver Program do not substitute for care provided in the New York State Medicaid State Plan or through the New York State Foster Care System.

Numerous research entities have cited the effectiveness of home and community based services programs including waivers and case management in preventing children from placement and hospitalization. Such studies including those from Fraser et al., 1996; Pecora et al., 1991 and the Homebuilders Program in Tacoma Washington, cited that between 75-90% of the children and adolescents who participated in such programs did not require placement outside the home. This research is also supported by the Report of the Surgeon General on Children's Mental Health, 1999. Hoagwood et. al also note that, "...studies of clinically oriented, intensive case management have found that children who have specially trained case managers require fewer restrictive services including psychiatric hospitalizations who do not". Solhkhah et al found that the Home and Community Based Services Waiver Program is "a clinically and cost effective way of maintaining children in their community by maintaining 81% of children in the community during an average period of twelve months versus a 30% rate for maintenance in the community for children on a wait list for waiver services. Use of case managers in community based interdisciplinary treatment teams has been found to reduce the number of placement changes and the number of runaway episodes among youth in foster care.[1]

Given the provisions of the B2H Waiver Program, and its very recent approval by CMS in July 2007, it appears that most, if not all of the provisions of the Interim Final Rule do not apply. However in reviewing the Interim Final Rule and in discussions with stakeholders, there are

[1] Report of the Surgeon General on Children's Mental Health, p. 172-175, 1999.

Hoagwood,. K., Burns, Barbara J., Kiser, L, Ringeisen, H, Schoenwald. SK. "Evidence-Based Practice in Child and Adolescent Mental Health Services:. Psychiatric Services Vol. 52, No. 9, September 2001, p.p. 1183-1184

Solhkhah, R., Passman, CL, Lavezzi, G., Zoffness, R, Silva, RR. "Effectiveness of a Children's Home and Community-based Services Waiver Program". Psychiatric Quarterly 78: 2007, p.p. 211-218.

several provisions that are confusing and may be misinterpreted. OCFS wishes to point out these in artful provisions to CMS. The provisions are as follows:

<u>Provisions of the Interim Final Rule</u>

<u>1.: Dual-certified B2H Waiver Services Providers Should be Protected:</u>

The Preamble to the Interim Final Rule (see page 68086) states: "we believe child protective services are the direct services of State child welfare programs and are not Medicaid case management. These activities of child welfare/child protective services are separate and apart from the Medicaid program. Thus, Medicaid case management services must not be used to fund the services of State child welfare/child protective services workers. "... Medicaid may not pay for case management services furnished by contractors to the State child welfare/child protective services agency, even if they would otherwise be qualified Medicaid providers, because they are furnishing direct services of the programs of that agency." OCFS believes this language has limited application to state agencies and as such, does not apply to the B2H Waiver Program.

If the Interim Final Rule did apply, it would be antithetical to the very purpose of the B2H Waiver Program. One of the essential elements of the B2H Waiver Program, approved and supported by CMS in July 2007, is the provision of the array of B2H Waiver Program services offered by Not-for-Profit Voluntary Authorized Agencies (VAAs), which are entities possessing the dual credentials: licensure as an OCFS foster care agency and licensure as a Medicaid provider licensed by the NYS Department of Health (DOH), Office of Mental Health (OMH) or Office of Mental Retardation and Developmental Disabilities (OMRDD). B2H Waiver Program service providers establish individualized care plans, coordinate Medicaid services, and or arrange for B2H Waiver Program services. B2H Waiver Program services include but are not limited to skill building, day habilitation, prevocational services, supported employment, special needs advocacy, and planned and crisis respite services. Only those entities having the specialized expertise and experience and able to demonstrate 'firewalls' between service provisions are authorized to provide B2H services. This is the lynchpin of the B2H Waiver Program and was clearly set forth in New York's applications to CMS.

2.: 15-Minute Service Increments for Case Management Do Not Encourage Quality Service: The Interim Final Rule appears to, at 42 CFR 441.18(a)(8)(vi), require that rates for case management services be calculated and billed in 15-minute increments, rather than the monthly billing currently in place. The flexibility inherent in the "person-centered approach" described at 72 FR 232, page 68082, and would appear to militate against such limitations for effective case management services.

The most significant change will be moving from a monthly unit of service to a 15-minute unit of service. This change would be drastic and would require time-keeping and documentation on such a detailed level that service coordinators' productivity and quality of service will be compromised. Rather than resulting in more individualized time with a client, the 15-minute unit of service would result in case managers, and the agencies that employ them with incentives to provide uniform one-size-fits-all services. This is the opposite of what the B2H Waiver Program is intended to do, and what CMS should want states to do---encourage economy, efficiency and services tailored to fit a person's actual needs. The increased complexity of billing in 15-minute increments will also increase the potential for increased Medicaid expenditures.

Case management services for the children participating in the B2H Waiver Program are not readily broken down into 15-minute units. Because this population is beset with multiple serious problems, services are often complex and multi-faceted. Artificially limiting the length of these sessions to 15 minutes will undermine the effectiveness of the services provided.

Moving from a monthly unit of service to a 15-minute unit of service will result in an administrative burden upon service providers that will ultimately compromise the quantum of actual services delivered to waiver participants. Time spent completing the additional records for 15-minute billing increments is time not spent with or for B2H participants. Rather than the comprehensive coordinated service delivery envisioned by the B2H Waiver Program, services will tend to be unnaturally fragmented and piece-meal.

3.: Transportation Services Rules are Confusing: The Interim Final Rule, at page 68082, is also ambiguous and confusing regarding reimbursement for transportation services provided in conjunction with case management. The B2H Waiver Program was approved by CMS with the understanding that case managers may transport participants to identified services when necessary. This is particularly true in rural areas, where there are often no other transportation options available. An interpretation that the Interim Final Rule precludes transportation as part of case management would frustrate one of the intents of the B2H Waiver Program- to provide participants with access to and involvement in their community. If transportation cannot be provided as part of case management, the service referral may be an empty promise. Utilizing the case manager's car to transport participants to services is more economical and much less stigmatizing than requiring the use of an ambulette where none is needed.

Regulatory Impact:

4.: The Interim Final Rule Regulatory Impact Analysis, at page 68089, contains the Secretary's certification that "...the rule will not have a significant economic impact on a substantial number of small entities." OCFS strenuously disagrees with this assertion. The service providers for the B2H Waiver Program are not-for-profit organizations. It is those service providers that will be responsible for the increased record-keeping and billing activities attendant to moving from monthly billing to 15-minute increments. Thus, the Interim Final Rule will have a significant and adverse impact on these small entities.

Finally, OCFS wishes to point out prior case history on applicability of federal rulemaking activities to our waiver status. The Interim Final Rule is silent as to its applicability to previously granted waivers, such as the B2H Waiver program. There is no authority for retroactive application of the Interim Final Rule, or the impending Final Rule to the B2H Waiver program. In the absence of express legislative authorization, the authority to promulgate regulations does not include the power to apply those regulations retroactively [Bowen v. Georgetown University Hospital, 488 U.S. 204, 109 S.Ct. 468 (1988).] The authority to promulgate these regulations is set forth at 42 USC §1302, and contains no such retroactive authority.

For the reasons set forth above, the Interim Final Rule and any subsequent final rule should be revised to specifically exclude programs operated pursuant to 1915 waivers.

Should you have any additional questions or concerns, please contact Dee Alexander, OCFS Federal Liaison at 518-473-1682.

Sincerely,

Gladys Carrión, Esq.

Gladys Carrión
Commissioner

cc: Office of Governmental Affairs:
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Chief of Staff

February 1, 2008

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: CMS-2237-ICF, Mail Stop C4-26-05

Following are the comments of the New York State Department of Health (DOH) on the proposed CMS regulations regarding Optional State Plan Case Management Services. Other New York State agencies that provide case management services will directly provide comments on these regulations and the impact on their programs.

This Department, as the Single State Medicaid Agency with oversight responsibility for Medicaid case management services has multiple concerns with these regulations which are detailed in the letter. The primary concerns break down into three areas:

Inadequate time frame for implementation – States cannot implement the far reaching changes required by these regulations by March 3, 2008. The changes to services, billing procedures and data systems will take, at a minimum, six months to effect.

Confusion on waiver authority - CMS should clarify that these rules do not apply to waiver services. If it CMS' position that these rules apply to waivers additional clarification should be provided.

Reduction in services – The overall effect of these proposed regulations is to limit sharply the states ability to provide Medicaid case management services to vulnerable populations. Among the most problematic provisions are those that would preclude states from covering patient escort and supportive counseling.

Specific Concerns with Proposed Regulations:

1. **Escort and counseling : [§441.18(c)(2)]**
As referenced directly above, client escort is an essential case management activity to ensure access to and receipt of appropriate services and includes client education and advocacy to eliminate barriers to services. Escort should not be considered a direct service but part of the referral process and ensuring linkage to care. Supportive counseling is a process of education and problem-solving to address client barriers to care and ensure receipt of services. Supportive counseling is particularly important for clients with mental health and/or substance use issues. It, too, should not be considered a direct service but a case management activity to ensure receipt of care.

2. **Reimbursement by Unit of Service: [§441.18 (a)(8)(vi)]**
This mandates fifteen (15) minute billing periods for case management as opposed to "bundled" per diem, weekly, or monthly rates that most Case Management (CM) programs currently use. Only certain of the New York State CM programs such as the Care at Home (CAH) waiver, the Teenage Services Act (TASA) program, the Early Intervention Program, and the HIV/AIDS Community Follow-up Program (CFP) currently reimburse providers in fifteen minute increments. All other New York State CM programs reimburse through a monthly capitated rate. The proposed incremental billing practice will require work to ensure fair and equitable reimbursement. Some program managers expect that the practice could result in increased program expense as set monthly rates define allowable service time as opposed to the unlimited 15 minute billing units. Implementation of the new regulations will require new reimbursement methodologies, change to all State documents related to CM billing practices, regulations and other provider materials, and to the New York State claims processing system.

CMS should continue to allow flexibility in reimbursement methodologies. Daily, weekly and/or monthly rates for service coordination are not a "payment for a bundle of services" (pg. 68085). Rather, they are payment for the single service of case management. Such rates can be set to be as accurate, reasonable and reflective of cost as 15 minute units. The proposed 15 minute unit is not a panacea for problems CMS may have encountered with daily, weekly or monthly rates. It is a unit for which it will be extremely difficult to set payment criteria e.g. does it legitimately include the 10 minutes a case manager waits to receive a call back from an prospective employer or landlord; it will lead to inefficient use of case managers' time, e.g. a case manager may speak with the prospective employer/landlord regarding three consumers during the same phone call/visit, but if the case manager is only paid for each 15 minutes attributable to individual consumers, the incentive is to make separate calls/visits to maximize reimbursement opportunities; it will complicate record keeping since each record will need to specify the specific time intervals; and it remains potentially more open to gaming than the other methodologies since the incentive is to waste time. It would be more instructive and beneficial to both states and CMS, if CMS were to share best practices in establishing cost-related rates or prices.

3. **Transition Services: [§440.169(c)], [§441.18(a) (8) (vii) (D,E)]**
   Currently, reimbursement for transitional case management (services provided while the recipient is in the facility for purposes of planning community care) varies by program. The new regulations will limit payment by length of institutional stay: short term (less than180 days) to fourteen (14) days, and long term (180 days or more) to sixty (60) days [§ 440.169(c)]. The rule further specifies that payment will not be made until the patient is discharged, enrolled in CM and receiving medical services in the community [§441.18(a) (8) (vii) (D,E)].

   This change is anticipated to negatively affect recipients with complex service needs and appears to be contrary to established best practices for care in the least restrictive appropriate setting. For instance, it is understood that some institutionalized patients may require extended CM prior to facility discharge in order to determine and arrange delivery of needed community care, especially if housing or certain specialized services are required.

   Some program managers report that the lag in payment may create a disincentive for early patient identification and service. Additionally, this change could leave providers vulnerable to unbillable service should the client decline community based CM enrollment or decide to remain in an institution. Advocates and providers can be expected to perceive this rule as having a negative fiscal impact on their organization and the individuals they serve.

4. **Single Case Management Provider: [§440.169]**
   There are distinct advantages to CMS' principle of a single case management provider, most importantly the positive benefit for a consumer and his/her family or informal supports to working with one individual accountable for a coordinated, integrated and holistic service plan. This can prevent gaps in responsibility, especially those which would be detrimental to the consumer's health and welfare in the community. However, just as CMS acknowledges layers of case management when an individual is enrolled in a managed care plan, CMS should allow flexibility for management of subspecialty needs e.g. mental health, developmental disabilities, as long as the system developed by a state assures coordination and clear placement of responsibility for a comprehensive service plan with one case manager who assumes responsibility for an integrated and comprehensive plan.

5. **Case Manager v Direct Service Provider Conflict of Interest: [§441.18]**
   Under the State Plan option, the provisions that states must ensure that conflicts of interest do not exist and that, if the case manager provider is also a qualified provider of other Medicaid services, the individual is given choice are valid, cost-

effective and respectful of consumer rights. However, it should be acknowledged there may be instances in which other service provider resources are limited, e.g. other service providers are not available within a reasonable distance who can meet special needs, including cultural needs, and the case management provider is the only appropriate agency. The relationship of the case manager to the service provider should be made transparent to the consumer, but the consumer should not be prevented from accessing the needed services if s/he chooses.

Within the context of 1915c waivers, states should be afforded more flexibility in modeling relationships between case managers and service providers. Consumers should retain the right to choose waiver models which integrate case management and services. For example, a selected waiver provider agency can provide directly and/or indirectly case management as well as a full range of waiver services. While not all consumers will prefer such an integrated model, many may have more confidence in it and find it affords continuity in an understandable approach. As long as the model is transparent to consumers to assure informed choice and checks and balances exist in the model to control for over or under utilization, integrated models can offer a quality, cost-effective option.

6. **Prohibition on Case Managers serving as "Gate Keepers": [§441.18]**
   This prohibition under the State Plan option remains valid. However, within the 1915c construct it is not sustainable if it is interpreted by CMS to mean case managers can not consider cost when developing service plans. Significant time is lost if plans which disregard cost are presented for approval to state officials or their designees who must evaluate the plan against CMS' cost neutrality mandates. The practical result is delays in transition to the community or institutionalization until an approvable plan is developed.

7. **Child Services: [§441.18]**
   The new regulations disallow payment for CM provided by child welfare agency staff or contractors which may significantly impact the new Bridges to Health (B2H) Medicaid waiver for children in foster care and other programs for children. As designed the B2H waiver will provide children CM through contracted Health Care Integration Agencies that may also be direct service providers. [Note: The New York State Office of Children and Family Services (OCFS) will provide detailed comments on this issue in their correspondence on this matter.]

8. **Clarification on Allowable Activities Prior to an IFSP: [§441.18(c)]**
   CMS acknowledges that "the Individualized Family Services Plan (IFSP) process for an infant or toddler with a disability under the age of three requires a service coordinator from the outset, some of whose activities may be Medicaid-funded case management. Covered case management services could include "taking the child's history, identifying service needs, and gathering information needed to form a comprehensive assessment." The NYSDOH interprets this statement to indicate that it is the intention of CMS to continue to allow reimbursement for

case management activities that happen prior to the *initial* IFSP, as such case management services would not by definition be included in a child's IFSP. CMS should amend § 441.18(c) to clarify that the exclusion does not apply to case management services provided for children referred to the Early Intervention Program (EIP) whose IFSP development is in progress.

9. **Conflict with IDEA Statute Regarding Use of Medicaid: [§1902(a)(25)]**

CMS states that "Case management services must remain separate and apart from the administration of Individuals with Disabilities Education Act (IDEA) services. Medicaid may pay for those case management services where IDEA and Medicaid overlap, but not for administrative activities that are required by IDEA but not needed to assist individuals in gaining access to needed services. These would include activities such as writing an Individualized Educational Plan (IEP) or IFSP, providing required notices to parents, preparing for or conducting IEP or IFSP meetings, or scheduling or attending IEP or IFSP meetings." Under Part C of IDEA, the development of the IFSP, including scheduling and attending IFSP meetings, is a critical step in assisting eligible children and their families to access needed services. In addition, § 440.169(d)(2) of the proposed interim rule includes development and periodic revision of a specific care plan as a case management activity funded by Medicaid.

Further, federal regulations implementing IDEA make it clear that the intent and requirement upon states is to use Part C funds as the payer of last resort for Early Intervention Program services and activities. Note 2 to 34 CFR §303.23 states that "the legislative history of the 1991 amendments to IDEA indicates that the use of the term service coordination was not intended to affect the authority to seek reimbursement for services provided under Medicaid or any other legislation that makes reference to "case management" services. Federal regulations at 34 CFR §303.126 require states to assure compliance with requirements pertaining to payer of last resort for use of Part C funds, including non-substitution of funds and non-reduction of other benefits; and, federal regulations at 34 CFR §303.522 requires the State lead agency to identify and coordinate all available resources for early intervention services within the State, including those from Federal, State, local, and private sources, including Title XIX of the Social Security Act (relating to the general Medicaid Program, and EPSDT). These regulations clearly state that scheduling and attending IFSP meetings should be considered reimbursed activities under Medicaid. At a minimum, CMS should revise the regulations to include these two service coordination activities as allowable.

10. **Clarification Regarding TCM for Children in Long Term Care: [§440.169]**

The New York State Early Intervention Program currently provides service coordination services to a small number of children who are receiving long-term care in skilled nursing facilities, or other residential programs, for health care purposes (e.g., ventilator dependent children) and their families. Such service coordination services are necessary to ensure that these children and their families receive access to early intervention services in their IFSPs. CMS should amend § 440.169 to clarify that service coordination services may be provided when a child is in a long-term care health care facility and such services are necessary to ensure the child and family continues to receive needed early intervention services.

11. **Service Coordinator Requirement in IDEA: [§441.18(a)(3)]**
IDEA and implementing federal regulations at 34 CFR Part 303 require that all children receiving EIP services be provided with one service coordinator (case manager) who is responsible for assisting and enabling a child to receive the rights, procedural safeguards, and services that are authorized to be provided under a State's Early Intervention Program (34 CFR §303.22(a)(1)). CMS should clarify that the prohibition at § 441.18(a)(3) does not apply to service coordination services which are required to be provided under other federal programs.

12. **Public Schools: [§441.18]**
Congressional intent was to shift in part the funding of the medical cost of IDEA services to the Medicaid program. By utilizing Medicaid, Congress ensured that the funds would go to the poorer schools where the funding is needed the most. It appears that CMS disregarded Congressional intent on this point.

The DRA definition for Medicaid targeted case management and the components cited is in concert with the New York State's school based targeted case management (TCM) process. The DRA requires TCM to include taking client history, identifying the needs of the individual, gathering information from other sources, development of a specific care plan, referral and related activities to help an individual, monitoring and follow-up activities and determining if services are being furnished and whether the services in the care plan are adequate to meet the needs of the individual. All of this is required under IDEA as well.

Congress has never met the level of IDEA funding promised to states and local education agencies. Allowing public school districts Medicaid reimbursement for targeted case management services helped narrow a still significant gap between actual federal fiscal participation and federal promises.

New York State and its public schools will lose approximately $60 million per year in federal funds for targeted case management services that are provided to the school based Medicaid population, increasing the burden on local tax payer's face.

13. **Payer of last resort: [§1902(a)(25)]**
Both Medicaid and HRSA (i.e., Ryan White HIV/AIDS Treatment Modernization Act of 2006) claim to be payer of last resort for case management services for HIV-positive persons. In New York, Medicaid supports intensive case management services for Medicaid-eligible persons living with HIV/AIDS through the Community Follow-up Program. The HRSA funding pays for supportive, non-

intensive case management, as defined in published standards of care, and for services for persons who are not eligible for Medicaid. The proposed regulations state if targeted case management is paid for by any other program, that funding must be used in place of Medicaid. Care must be taken to assure that these distinct services continue to be supported and available to persons living with HIV infection.

We would urge CMS to revise the proposed regulations to more closely reflect the language and intent of 42 CFR, Parts 431, 440, and 441. Whatever cost savings these regulations would achieve in the short-term will be more than offset by additional costs resulting from this change in federal policy.

Sincerely,

Deborah Bachrach

Deborah Bachrach
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

New York State
OMH
Office of Mental Health

44 Holland Avenue
Albany, New York 12229

February 1, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2237-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

VIA OVERNIGHT MAIL

Re: CMS-2237-IFC

Dear Acting Administrator Weems:

Enclosed please find comments submitted on behalf of the New York State Office of Mental Health on the Interim Final Rule with Comment Period, which amends 42 CFR Parts 431, 440 and 441, and was published in the Federal Register on December 4, 2007.

Very truly yours,

Michael F. Hogan, Ph. D.
Commissioner

COMMENTS SUBMITTED ON BEHALF OF THE NEW YORK STATE OFFICE OF MENTAL HEALTH [CMS-2237-IFC]

The New York State Office of Mental Health ("OMH") has four "targeted case management" ("TCM") programs, all of which are operating pursuant to approved State Plan Amendments. The four programs (Intensive Case Management ("ICM"), Supportive Case Management, Blended Case Management, and Blended and Flexible Case Management) all use a monthly case payment for reimbursement, but differ based upon the level of disability of the individuals served and the credentials required by the program staff. All four programs are well-established in the state, beginning with the Intensive Case Management program, which was approved by CMS' predecessor, the Health Care Finance Administration ("HCFA"), in 1990.

In addition to the TCM programs, OMH also operates a Home and Community Based Services Waiver ("H&CBSW") for emotionally disturbed children, that was approved by HCFA in 1995, and therefore has been in operation for over thirteen years. This highly successful program, one of the first in the nation, provides Individualized Care Coordination ("ICC") for children and families, which may be considered to be case management. The ICC authorizes Waiver services based on the treatment plan developed in conjunction with the child and family. Although it did not appear from the Deficit Reduction Act of 2005 (DRA) that Congress intended the provisions regarding case management to cover services other than TCM, OMH has been informed that CMS has publicly stated that the regulations will also cover H&CBSW case management. Our comments on the regulations therefore cover both TCM and the H&CBSW's ICC.

The Interim Final Rules proposed by CMS are ostensibly being promulgated pursuant to the DRA. OMH is concerned, however, that the regulations go far beyond the language of that Act, and its intended scope, and do so in a way that threatens to negatively impact upon OMH's ability to provide much-needed case management services in an effective manner.

CASE MANAGEMENT FOR PERSONS IN INSTITUTIONAL SETTINGS

One of the examples of CMS overstepping the boundaries of the DRA legislation is 42 CFR 440.169(c), which deals with individuals being discharged from inpatient settings or institutions. The proposal does two things: First, it shortens the period during which a person may receive case management services while in an institution from 180 days to 60 days for a long term institutional stay of 180 days or longer; and for an institutional stay of less than 180 days only allows case management services to be provided during the last 14 days of discharge.

Second, in addition to shortening the amount of time during which case management can be provided, under the proposed rule the services provided while the person is in the institution cannot be billed until after the person leaves the hospital. Nowhere in the DRA were either of these issues addressed.

Restricting case management services to the last 14 days of a hospital stay raises several issues for mental health providers. The date of discharge is not easily determined in mental health care. Mental illness typically involves periods of remission and exacerbation that are unpredictable. If a program provides services, based on an anticipated discharge date, and then the client takes a turn for the worse and is not able to be discharged at the end of the fourteen days, the case management program would be unable to bill for any services provided during the additional time period.

In addition, if a person is institutionalized for 180 days, frequently they will have lost access to their community living situation. One of the problems that many mentally ill individuals face at discharge is the difficulty of obtaining housing. In New York City, obtaining affordable housing is particularly difficult. If one looks at the history of case management, one of the original reasons HCFA allowed case management was to address the issue of homelessness. The State Plan Amendment ("SPA") for OMH's ICM program lists two of the four categories of target groups as: "extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community;" and "mentally ill who are homeless and live on the streets or in shelters" Both groups will obviously be in need of housing assistance.[1] Finding affordable housing is not a task that can necessarily be done within fourteen days. Additionally, hospital discharge planners are not equipped to look for housing for patients–their job is to link the individual to outpatient medical and mental health services, including TCM. Linking to housing is one of the jobs of the TCM staff. Although this is primarily an urban problem, it is a problem faced in urban settings other than New York City. The regulation as drafted is likely to lead to increasing homelessness, which is antithetical to the original intent of the case management programs approved by HCFA/CMS.

In addition, and importantly, the language regarding case management services in the Interim Regulation **contradicts** a previous letter sent to State Medicaid Directors on July 25, 2000, which was sent to assist the State Medicaid Directors by HCFA. HCFA informed the States that the letter was intended to provide clarifications or changes in policy in response to the Olmstead v. L. C., 527 U.S. 581 (1999). In an effort to assist the States in coming into compliance with Olmstead, HCFA sent out a series of directives to assist States with developing community alternatives to institutionalization. One of the attachments to the July 25, 2000 letter, 3B, dealt with case management policy changes. That Attachment stated as follows:

> A. Case A. Case management. Case management services are defined under section 1915(g)(2) of the Social Security Act (the Act) as "services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational, and other services." Case management services are often used to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community. There are several ways that case management services may be furnished under the Medicaid program:
>
> > ...Targeted case management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community. We are revising our guidelines to indicate that TCM

[1] Target groups in the Blended and Flexible Case Management program, the Flexible Case Management program, and the Supportive Case Management program also include these target groups.

> **may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition. States may specify a shorter time period or other conditions under which targeted case management may be provided. Of course, FFP is not available for any Medicaid service, including targeted case management services, provided to persons who are receiving services in an institution for mental disease (IMD), except for services provided to elderly individuals and children under the age of 21 who are receiving inpatient psychiatric services.** (bolding added.)

As a result of that transmittal, OMH amended its regulations to allow case management providers to bill for services provided to persons receiving targeted case management services who were institutionalized. The current regulation states that:

> Individuals who have been admitted to discrete psychiatric units of hospitals licensed pursuant to Article 28 of the Public Health Law, residential treatment facilities for children and youth, or individuals 21 years of age or less or 65 years of age or older who are receiving services at State-operated psychiatric facilities or hospitals licensed pursuant to Article 31 of the Mental Hygiene Law and who have an anticipated discharge within 90 days or less, may receive case management services. Such services shall be billed pursuant to the standards established in Sections 506.5, 506.6 and 506.7 of this Part, if such services are required in order to facilitate the process of transition to community services and to enable the individual to gain access to needed medical, social, educational, and other services in the community. (14 NYCRR Section 506.10)

This section, revised in accordance with HCFA's instructions, would be invalid under the Interim Final Rule. More importantly, the proposed change would undermine the expressed goal of facilitating the transition of individuals from institutional to community settings, and jeopardize States' ability to comply with <u>Olmstead.</u> Ultimately, such a policy is also self-defeating, because it will inevitably result in longer and more expensive hospitalizations, rather than an expeditious return to less expensive outpatient care. Finally, CMS' Interim Final Rule effectively repeals previous HCFA interpretations on this issue, without any intervening statutory changes to support such re-interpretation.

The provision in the prohibiting case management providers from billing while the person is in the institution also presents a problem. Since in New York State case management bills are submitted at the end of a month, this rule would put the program in the position of providing services for up to 90 days before it can bill Medicaid.[2] Programs are not so richly funded that they can afford to provide services for which they are not paid for several months. The cash flow issue is such that programs will be reluctant to provide services for which they cannot be timely paid.

CASE MANAGEMENT ACTIVITIES

Of great concern to OMH is this CMS comment contained in Section III. CMS states:

> Referral and related activities do not include providing transportation to the service to which the individual is referred, escorting the individual to the service, or providing child care so that an individual may access the service. The case management referral activity is completed once the referral and linkage has been made.

This statement shows a complete lack of understanding about what the role of a case manager is, and more importantly, what the needs of the disabled populations are, including individuals with mental illness. Case management services are defined under section 1915(g)(2) of the Social Security Act (the Act) as "services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational, and other services."[3] If a mere

[2]Even if the State did not reimburse on a monthly basis, but on the 15 minute basis CMS is now requiring, there would be at least a 60 day delay in payment.

[3]The SPAs approved by HCFA, then CMS, define as a case management function, in section D, "Implementation of the case management plan," as "...securing the services determined in the case management plan to be appropriate for a particular recipient through

referral were all that was needed, case management need not exist. Although OMH agrees that it is not a case manager's responsibility to provide child care (OMH provides State-only dollars for case managers to purchase child care if deemed necessary), it is certainly the role of a case manager to escort a person to services if necessary, to perform the "advocacy" and "linkage" necessary to assure that the individual receives the appropriate services. For persons with a serious mental illness, it is often the case that as a result of functional deficits associated with their illness, unless they are escorted to services, they are unable to access them. How can a case manager advocate for a client, or assist in application forms, unless he or she is present and able to work with the service provider to assure that the goals of the case management plan are met?. This is not a job that can generally be performed in the office, but much of it must be done in the field, going with the client to various service providers, housing providers, etc. in order to assure that the plan is implemented, or modified if necessary. The purpose is not to provide transportation, or an "escort," but rather to be on the scene (and assure the client is on the scene) "to enable the individual to gain access to needed medical, social, educational and other services in the community."

LIMITATIONS ON CASE MANAGEMENT SERVICES

CMS has stated that it will apply the provisions of this proposal relating to freedom of choice of providers to "case management services" provided in Home and Community Based Services Waivers. This would be another area in which CMS clearly overstepped the statutory authorization of the DRA. It would also undermine the structure and value of the waiver program.

OMH operates a waiver for emotionally disturbed children and has done so for over ten years. Enrollment in the plan is voluntary. One of the components of the waiver is the Individualized Care Coordinator, a professional, who along with the family and child, designs a

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referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of services; and developing alternative services to assure continuity in the event of service disruption." This definition comports with the statute and was approved by HCFA many years ago.

service plan. Waiver services cannot and should not be accessed without the development of the plan. It appears from the language of the CMS "explanation" of the regulations that CMS would require OMH to allow a child to be enrolled into the waiver without an Individualized Care Coordinator. This is contrary to OMH's design of the waiver, as well as to the intent of the H&CBW program generally, which is intended to permit states to develop innovative programs for individuals who would otherwise be at risk of hospitalization, and thereby keep them in the community, while spending no more than what such persons would cost in an inpatient setting. Without a case manager to authorize services (in conjunction with the child and family) which comport with the service plan, there can be no control over the amount and cost of services. This would make it difficult, if not impossible, to assure that the prospective cost of the program would not exceed that of inpatient care, as is required by Medicaid law, to meet the federal "fiscal neutrality" cap. In addition, it is the ICC that is responsible for the assessment of the child's needs and develops the service plan, and without ICC as a service, who would develop and monitor a clinically appropriate plan? It is difficult to see how any waiver can be operated without a case manager who performs both functions.

BUNDLED RATES

The proposed regulations further exceed the scope of the DRA by prohibiting the use of so-called "bundled rates" for case management services. Nothing in the DRA addresses this issue, nor is there any provision in existing Medicaid law or regulations which would prohibit such rate methodologies. CMS appears to be using the DRA as a pretext for inserting into regulations a provision which has no basis in Medicaid law, the DRA, or, until this publication, in regulation.

OMH has used monthly case payment rates since the implementation of its ICM program[4], pursuant to approved State Plan Amendments. In approving a State Plan Amendment, CMS is certifying that the manner of providing and financing the services set out in that SPA are consistent with Medicaid law and regulations. Medicaid requires that reimbursement methodologies adequately reimburse for services provided by "efficiently and economically

[4] And for all its other TCM programs, and for the ICC payment in the Waiver program.

operated" providers. There is nothing inherent in a bundled rate that fails to meet that standard, nor did HCFA or CMS find that a bundled rate was not "efficient" or "economic" until recently. In this instance, and in many others, a monthly case payment is the most efficient and economic manner of reimbursing a case manager.

It should also be noted that the term"bundling" in this instance is a misnomer. Bundling is generally used in health care to define the compensation of a package of different services within a single rate. Bundled services are used in institutional settings, where a person may get physical therapy, occupational therapy, a physician's service, and one inpatient rate is "bundled" together and billed. In the case of case management, however, services of a different variety are not being provided–all of the services provided are defined as case management services. The use of the term "bundling" is therefore inappropriate.

In OMH's case, rates are determined by taking the cost of the program, including salaries and some overhead, and dividing it by the case load. (The State pays for those clients who are not eligible for Medicaid and who do not have the resources to pay for some or all of the cost of the service.) All clients must be seen a certain number of times monthly in order to bill. Some clients are seen more than the minimum number required to bill, because their condition is more acute. Depending on the month, different individuals will receive more services than the minimum required to bill, based on their acuity or changes in their situation, and some will only receive the minimum number of services.

The current payment methodology allows for flexibility to reflect the fact that clinical needs and situations change. A pure "fee for service" 15 minute rate would not allow for that same flexibility. Nor does the requirement to bill in 15 minute increments make any sense for case management services. Most case management services for a disabled population take far longer than 15 minutes. Very few case management services involve an activity of that short a duration, nor is there any inherent reason why methodologies that do not employ such a measurement are inconsistent with efficiency or economy. For CMS to deem 15 minute increments as the measure that should be used goes far beyond its authority. It is authorized to monitor programs to assure that they are economically and efficiently operated. ***CMS is not authorized to set the unit of time for reimbursement in a regulation.*** This micromanagement is beyond anything that CMS has attempted to date. It is harder to think of a more efficient and economic system than what is currently in effect in OMH's programs. It does not require "...substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures." There is no profit made by these programs, and in some instances the State must in fact meet their deficits because not all clients are Medicaid eligible.

Further, for CMS to expect that an entire billing system, for all four of OMH's TCM program, plus the waiver program, can be converted to 15 minute billing increments by March 4, 2008, is completely unrealistic. New rates would have to be set, programs would have to be trained in the new billing process, the electronic billing system would have to be re-programmed, a process that could not possibly be achieved by March 4, 2008. In addition, OMH would presumably have to amend its currently approved SPA's and submit an amendment to its Waiver application to reflect the necessary changes. This is a lengthy process which cannot be accomplished in the time frames specified.

CONCLUSION

Therefore, OMH respectfully requests withdrawal of all sections of the Interim Final Regulation on Targeted Case Management. In the alternative, CMS must recognize the inherent difficulties for States to comply with this regulation in the time frame given, and should allow a period of up to two years to comply with the necessary changes. Finally, CMS should provide a statement that the Interim Final Regulations are not and were not intended to cover Home and Community Based Services Waiver programs.

Eliot Spitzer
Governor

Diana Jones Ritter
Commissioner

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February 1, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2237-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

VIA OVERNIGHT MAIL

Re: Optional State Plan Case Management Services Interim final rule with comment period CMS-2237-IFC

Dear Acting Administrator Weems:

The New York State Office of Mental Retardation and Developmental Disabilities ("OMRDD") submits the following comments on the Interim Final Rule with Comment Period ("the Rule") published in the Federal Register on December 4, 2007 at 72 Fed. Reg. 68077 regarding Optional State Plan Case Management Services.

OMRDD is the State agency responsible for providing and overseeing services to persons with developmental disabilities in New York State. Since its creation as an independent agency in 1978, OMRDD has succeeded in transforming New York's services for persons with developmental disabilities from large institutional services to services that help persons live with dignity as independently as possible in the community, respect their choices, and ensure them quality services. Each day approximately 126,000 persons receive services in OMRDD's system. One of the key components of OMRDD's system is targeted case management. This service ensures that each person gets the services he or she needs, that the services reflect his or her individual choices, that the services are coordinated and that the person's safety and health are maintained.

OMRDD could not have achieved this service system transformation without the strong partnership of the federal government, and OMRDD cannot continue to ensure that New Yorkers with developmental disabilities maintain their health, safety, dignity and participation in society without continued federal support.

With this in mind, OMRDD strongly objects to certain provisions of the Rule and in general to the manner in which the Rule was adopted. It is true that the Deficit Reduction Act of 2005 (DRA) required CMS to adopt a regulation reflecting the DRA's substantive provisions on Medicaid targeted case management on an interim final basis. Deficit Reduction Act of 2005, §6052(b). Yet in spite of the fact that the DRA did not require or even authorize CMS to adopt an interim final regulation containing additional changes to the rules for case management services, this is exactly what CMS has done. Numerous provisions of the Rule (such as the 15 minute unit of service) go far beyond anything even remotely contemplated by the DRA and are major changes in the federal requirements. This overreaching, the lack of prior comment, consultation or any other meaningful dialogue with affected parties, and the extremely short time between the Rule's announcement and effective date virtually ensure that states and providers will be out of compliance.

Below are OMRDD's objections to specific provisions of the Rule.

Fifteen Minute Unit of Service

The Rule requires that all payment and rate methodologies for case management services use a unit of service of 15 minutes or less. CMS claims that a 15-minute unit of service is necessary to meet the requirement of Social Security Act §1902(a)(30)(A) that payments be consistent with efficiency, economy and quality of care. To the contrary, requiring 15 minute billing increments will result in payments that are inefficient, uneconomical and detract from quality of care.

There is nothing in the text of §1902(a)(30)(a) that addresses a unit of service, much less anything that requires one particular type of a unit. Nor is there any case law interpreting this provision that requires any particular unit of service.

Instead of citing specific statutory language or case law, CMS simply asserts that "bundled" payment methodologies are not "consistent with" §1902(a)(30)(A). (By "bundled", CMS means payment at one rate for a group of services of the same type delivered over a fixed period of time. According to CMS, any daily, weekly or monthly rate is a "bundled" rate.) CMS claims bundled rates are not "reflective of the actual types or numbers of services provided or the actual costs of providing the services" and therefore are not "accurate or reasonable payments" and might "result in higher payments than would be made on a fee-for-service basis for each individual service." CMS also states that a "bundled" rate is not consistent with economy because the rate "is not designed to accurately reflect true costs or reasonable fee-for-service rates." There is no support for any of this in law or fact.

These statements imply that cost-settling and fee-for-service methodologies are the only ones allowed under the statute. This is not true. There is nothing in The Social Security Act requiring states to use one of these methodologies, limiting payments to actual cost or requiring payments to "reflect" actual costs. The only provision of the law that contained such a requirement applied to institutional services and was long ago repealed by Congress and replaced with standards that were modified over time to give states ever increasing flexibility in devising payment methods.* (There is nothing to support a view that requirements for payment of non-institutional services have somehow undergone a tightening over this same time period. Moreover, there is absolutely nothing in the law that sets fee-for-service payments as an upper limit on reimbursement for any service, no less case management (assuming one could even calculate what a fee-for-service payment would yield).

Even if one assumes, for the sake of argument, that there is a requirement that rates somehow "reflect" costs or the number or types of services, there is nothing in the nature of daily, weekly or monthly rates preventing them from doing so. If the rates are based on accurate and sufficient data, they will in fact reflect actual costs and quantity of services, whether they are cost-based, fee-for-service or daily, weekly or monthly rates.

Moreover, daily, weekly or monthly rates do not necessarily generate higher payments than fee-for-service payments would generate. In fact, depending on provider behavior and how the fee is set, it is equally possible that a fee-for-service system would generate higher payments. A fee can be set far above actual cost. In a fee-for-service system, the higher the volume of services, the higher the payment to providers. Providers have every incentive to "over serve" people. Because case management by definition includes reassessing a person, gathering information, revising care plans, monitoring and follow-up, and because there is no professional or clinical standard for how often or how much these activities should be performed, it will be difficult for states, CMS or other oversight entities to question a case manager's billable units and prevent milling. In contrast, one of the benefits of a daily, weekly or monthly rate is that it removes any incentive to mill.

* Former Social Security Act §1902(a)(13) originally required states to pay the "reasonable cost" of hospitals (Social Security Amendments of 1965 §121(a), Pub. L. 89-97). It was changed in 1972 to require payment on a "reasonable cost related basis" (Social Security Amendments of 1972 §249(a), Pub. L. 92-603), then in 1980 to require payment at rates that were "reasonable and adequate" to meet the costs of efficiently and economically operated facilities (Omnibus Reconciliation Act of 1980 §962, Pub. L. 96-499), and finally in 1997 to only requiring public notice and comment (Balanced Budget Act of 1997 §4711(a), Pub. L. 105-33).

CMS also states that a bundled rate is not consistent with efficiency because it will take more federal auditors to "establish the accuracy and reasonableness of State expenditures." There is nothing in the statute to justify this truly singular interpretation. Section 1902(a)(30)(A) requires that rates be "consistent with efficiency, economy and quality of care." The standard of "efficiency" is immediately juxtaposed with "economy" and "quality of care," both of which describe provider characteristics, not government oversight agency characteristics. Taken together, these words mean that states are not allowed to have payment methodologies that reward or pay providers for being wasteful or extravagant, but that they must still pay providers enough to render quality care. Also, the phrase "consistent with efficiency, economy and quality of care" is in a passage that requires states to safeguard against unnecessary utilization of services and to have payments high enough to ensure sufficient numbers of providers participate in Medicaid. All of these requirements speak to provider operations and beneficiary protections. There is absolutely nothing in §1902(a)(30)(A) that refers to the operations of CMS or HHS or to making the job of CMS or HHS auditors easier.

In practice, 15-minute billing increments will do nothing to encourage efficiency, economy or quality of care. Case managers will have to track and document time in 15 minute increments. This will take time away from service, of course, but in a much more detrimental way than it would for other, more medical services. Because case management is not a routine service, case managers and their employers will not be able to devise standard, quick and easy documentation systems. Instead, case managers will have to document each unique 15-minute task. This will take time and focus away from the delivery of service.

Finally, states will have to invest substantial time and resources to design billing and payment systems, and to train state staff, state auditors and state and private case managers. States will also have to invest a huge amount of time and effort into determining what a 15 minute rate should be. This will involve gathering and analyzing data on things such as case management salaries, time spent on direct case management tasks, time spent on indirect tasks (such as attending training and record-keeping) and indirect costs (such as supervision).

Freedom of choice

The Rule has several restrictions allegedly based on the free choice of provider principle. First, the Rule prohibits states from restricting a recipient's choice of case management providers, as long as the providers are willing and qualified (including qualified under a state's limitations for case management for persons with developmental disabilities). OMRDD does not object to this restriction.

Second, the Rule prohibits states from generally mandating that recipients receive case management, and from requiring recipients to receive case management as a condition of receiving other Medicaid services. OMRDD does not object to the restriction prohibiting states from *carte blanche* requiring Medicaid recipients to receive case management. However, OMRDD strongly objects to the restriction preventing states from requiring case management for those recipients receiving particular services.

CMS claims that this provision is mandated by Social Security Act §1902(a)(19), which requires states to provide services in a manner consistent with the best interests of recipients, and Social Security Act §1902(a)(23), which requires that recipients be able to receive services from any willing and qualified provider. OMRDD currently requires persons who receive services through the HCBS waiver to also receive targeted case management. This case management service not only ensures access to and coordination of services, but also ensures the recipient's health and safety. Case managers are required have a face-to-face meeting with the person each month, with one visit each quarter being at the person's home. As OMRDD serves more people in their natural homes instead of in licensed residential settings, this health and safety function of the case manager becomes essential. Allowing these persons to receive HCBS waiver services without any kind of case management is not in their best interests. At best, it will lead to duplicate and unnecessary services; at worst, it will allow harmful and dangerous situations to go undetected. There is a freedom of choice requirement in the law, but it has to be read in conjunction with other provisions of the law, such as the requirement that a state safeguard the health and welfare of HCBS waiver participants (Social Security Act §1915[c][2]).

Finally, the Rule prohibits states from denying case management services to recipients who are not receiving any other Medicaid services. As a practical matter, this is unworkable. By definition, case management consists of assessment of needs, developing a care plan, referral to services, and monitoring and follow-up. (Social Security Act §1915(g)(2)(A)(ii), as amended by the DRA.) There is no point in assessing needs if the person is never going to receive services to meet those needs; there is no point in developing a plan of care if the person is never going to receive the care, and it is not possible for a case manager to make referrals, monitor services and follow-up if there is nothing to refer the recipient to, monitor or follow-up on. Again, CMS cites Social Security Act §§1902(a)(19) and (23) as the reason for this provision. However, there is nothing in the text of these provisions that require such an extreme application of the free choice principle. These provisions must be read in conjunction with other provisions of the Social Security Act, including the provision which requires states to have methods to prevent unnecessary utilization of services (Social Security Act §1902(a)(30)(A)). If one takes CMS' interpretation of the free choice principle to its logical conclusion, a Medicaid beneficiary could demand anesthesia without an underlying medical operation.

Case managers as gatekeepers

Closely related to the freedom of choice provisions is a provision of the Rule which prohibits case managers from restricting a person's access to other Medicaid services or from authorizing or denying Medicaid services. While OMRDD does not use case managers to perform either of these functions, we are concerned that the broad wording of the regulation would allow CMS to enforce it in a way that will lead many states to inadvertently violate this provision. For example, case managers in OMRDD's system are responsible for writing and updating individual service plans, which prescribe needed services and supports.

Persons transitioning to community services

The Rule limits payment for case management delivered to persons planning to enter the community from institutions. FFP is only available for case management provided during the last 60 days a person is in an institution if the person's institutional stay was 180 days or longer, and for the last 14 days a person is in an institution if the stay was less than 180 days. The net effect of this provision of the Rule will be to hinder OMRDD's efforts to move persons from institutions to the community, in contradiction to the Supreme Court's decision is *Olmstead v. L.C.*, 527 U.S. 581 (1999). OMRDD is continuing its efforts to move persons from intermediate care facilities for the developmentally disabled (ICF/DDs) to community settings. Developmental disabilities manifest themselves early in life and do not go away. Most of the people now in ICF/DDs have lived there much longer than 180 days; some have lived there their entire lives. It takes an average of three to six months to plan a person's move from an ICF/DD to the community. For many people, it is not a matter of resuming their lives in the community; it is a matter of creating a life in the community from scratch. Moreover, in spite of all the best work in the world, planned moves to the community are often delayed because of circumstances outside the control of those arranging the move, such as health or behavior episodes, delays in a community provider opening a residence or an apartment that was supposed to be available suddenly falling through.

Prohibition on duplicate payments

Under the Rule, FFP is not available for expenditures for case management "activities" that are an "integral component" of another Medicaid service. It will be impossible for practitioners to follow this requirement. The wording is so imprecise as to leave the state and service providers with virtually no guidance about when the case manager may actively ensure the person's health and safety when transitioning between Medicaid services. Further, it offers no specific guidance about which Medicaid services have "integral case management functions," leaving it to the targeted case manager to intuit what other services do for the person.

Several examples illustrate how this provision of the Rule will simply not work in practice. Example #1: a case manager refers a person to a clinic to receive a physical therapy evaluation. The physical therapist's report to the case manager then recommends that the person be seen by a neurologist to evaluate certain neuromuscular symptoms. The case manager does not know if the physical therapist will make the referral and follow up or if those steps fall to the case manager. If the physical therapist declines making the referral, the case manager faces the dilemma of neglecting the person's health and welfare by taking no action on the referral or making the referral and risking an auditor disqualifying the claim. Example #2: person with diabetes receives services at a clinic. The clinic coordinator's role is to refer persons to services within the clinic. The clinic coordinator receives a report from the clinic nurse practitioner that the person needs to be seen by an endocrinologist, a medical specialty unavailable through the clinic. The clinic coordinator does not make the referral because endocrinology is not a clinic service. The clinic coordinator passes along the referral to the case manager. The case manager will not make the referral because it may be a function integral to clinic and therefore not billable as a targeted case management service.

The Rule also states that case management "services" cannot duplicate "payments" to public agencies or private organizations under Medicaid or other programs. We find this language incomprehensible, because services and payments are two different things.

In conclusion, as written, the Rule is not only likely to create confusion and hardship among states and case management providers, but also actual harm to the individuals who require case management services to navigate health care systems and to live independent, productive and dignified lives.

Sincerely,

Patricia Martinelli
Deputy Commissioner and Counsel

February 15, 2008

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Waxman:

As requested by the Committee, the NYS Department of Health has prepared the enclosed information relevant to the six Centers for Medicare and Medicaid Services (CMS) regulations released over the past year as identified in your letter dated January 16, 2008.

Please be advised, as this information is studied, that the fiscal impacts of the proposed regulations are in some instances partially overlapping because they have similar negative impacts on programs. Because of the potentially devastating results these actions could create, it is imperative that the potential impact of each individual regulation be separately presented. It also bears mentioning that some aspects of these regulations could potentially lead to an increase in Medicaid costs by creating incentives for more costly acute care services.

We hope that this information and analysis of these specific CMS proposals is helpful in determining the immediate and long-term effects of these ill-conceived proposals. If you have further questions, please contact me at (518) 474-3018.

Sincerely,

Deborah Bachrach
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosure

cc: Tom Davis
Ranking Minority Member

CMS REGULATORY ACTIONS: NEW YORK STATE IMPACT

RECENT CMS ACTIONS

The Centers for Medicare and Medicaid Services (CMS) has embarked on a series of administrative actions that shift costs from the federal government to the States and drastically reduce federal funding for critical Medicaid providers, including state agencies, local governments, teaching hospitals, and school districts.

The proposed and threatened administrative actions are a substantial departure from past practices and reflect new and unsupported interpretations in Medicaid law. Almost all of the statutory provisions that CMS is "clarifying" have been in place for at least 15 years and some have been part of Title XIX since the inception of Medicaid in 1965.

CMS recently evaded Congress's attempt to place a moratorium on some of its proposals by sending the new rules to be finalized just hours before the moratorium was signed into law, rendering the moratorium all but moot. ***Since then, CMS has promulgated several rules that are the opposite of expressed Congressional intent – and which violate both statute and moratoriums already in place.***

RULES PUBLISHED BY CMS

The CMS proposals that will shift costs to the States and reduce Medicaid funding are summarized below, along with the effect these proposals will have on New York.

1. Provider Tax Regulations

On March 23, 2007, CMS proposed changes to the rules that regulate state taxation of healthcare related entities. The current rules were put in place in 1992, after extensive negotiations between states and the federal government, to establish clear-cut rules governing the types of taxes that could be collected by states from health care providers.

The proposal issued in March would essentially undo the current framework by allowing CMS to deem any tax impermissible based on a subjective determination that there is a "linkage" between the tax and Medicaid or non-Medicaid payments. If a tax is found impermissible, CMS reduces federal Medicaid funding to the State by fifty percent of the entire amount collected from the tax, regardless of whether any portion of the tax is actually reimbursed by Medicaid with a federal share.

Impact on New York State

New York has a number of provider taxes, including taxes on nursing facilities and hospitals. The vagueness and subjectivity of the new rule means that there is no absolute assurance that New York's taxes are protected. If New York's taxes are deemed impermissible under the proposed rule, the State could suffer up to hundreds of millions of dollars in disallowances of federal Medicaid funding annually. This would affect funding for uninsured and underinsured individuals served by Child Health Plus, Family Health Plus, Healthy NY and the Elderly Pharmaceutical Insurance Programs. Other vulnerable populations receiving support from these revenue sources include those infected with HIV/AIDS, those suffering from cancer, and individuals with mental health and developmental disabilities.

2. Outpatient Hospitals and Clinic

On September 28th, CMS published a rule that redefines what Medicaid can reimburse under the hospital outpatient benefit to include only those services Medicare reimburses through its more restrictive definition of outpatient hospital services. Hospitals would not be reimbursed under the hospital outpatient benefit for such things as: hospital based physician services; routine vision services; annual checkups; vaccinations; school-based services; and rehabilitation services. Note: Many of these services may still be reimbursable under Medicaid if provided under a different category of service.

CMS also redefines how States must calculate Medicaid upper payment limits (UPLs) for hospital outpatient and non-hospital clinic services. UPLs establish the maximum amount Medicaid can pay for these services. CMS's proposed UPL methodology is highly restrictive and administratively burdensome. CMS proposes to require the State to calculate UPLs for hospital outpatient services based on specific Medicare cost report worksheets that do not reflect graduate medical education costs of teaching hospitals or costs of many other services provided in New York's hospitals, such as physician services. Additionally, CMS proposes that the UPL calculation for non-hospital clinic services be based on Medicare fee schedules, which also do not recognize many of the unique costs and services provided by NYS providers. New York may be the only state in the nation that provides a substantial portion of its non-hospital Medicaid outpatient services through facilities rather than individual practitioners. This factor alone makes CMS's UPL rule untenable for New York.

The above described service and UPL driven payment restrictions would not only decimate the current outpatient and clinic health care delivery systems in New York, but would also create insurmountable obstacles to the State's ambitious primary care agenda. The State is embarking on a major initiative to reform its outpatient and clinic reimbursement systems and invest in increased access to preventive care, which will ultimately result in cost efficiencies and improved health outcomes in the State's overall Medicaid program. These goals cannot be reached if this regulation is not stopped.

Impact on New York State

NYS Medicaid spending is nearly $2.1 billion annually for hospital outpatient and non-hospital clinic services, of which nearly $1.2 billion is for mental health, developmental disability and substance abuse services. While it is difficult to determine the exact fiscal impact of this regulation on New York's health care delivery system, we anticipate that there would be a significant loss of federal Medicaid funding. Worse yet, absent Congressional action or litigation, CMS may attempt to apply aspects of the regulation retroactively. Further, the rule violates the Congressionally enacted moratorium that precludes CMS from implementing regulations that change Medicaid financing practices or eliminating Medicaid GME funding. The changed definition of hospital outpatient services could also impact the amount that can be paid under the Medicaid disproportionate share hospital program, which subsidizes hospitals for indigent care services.

3. Targeted Case Management

On December 4, 2007, CMS published an interim final rule regarding optional case management and targeted case management (TCM) services. The regulation will become effective on March 3, 2008. This regulation, in part, implements Section 6052 of the Deficit Reduction Act (DRA); however, it goes beyond what was authorized in the DRA. In addition, there is an inherent contradiction with the Ryan White statute.

This rule would reduce the number of days an individual can receive TCM services, prohibit payment for transitional case management services provided to inpatients being discharged until an individual is in the community, limit state flexibility to manage the Medicaid program and require providers to bill in increments of 15 minutes of less (not part of DRA). Further, this proposal would restrict funding for New York's Bridges to Health (B2H) waiver for foster children, which was approved in 2006.

Impact on New York State

New York has a number of case management programs including but not limited to: 1) early intervention (EI) services for infants and toddlers with disabilities; 2) school-based health services for students with disabilities; 3) teenage services pregnant or parenting adolescents; 4) AIDS follow-up programs; 5) intensive case, supportive case and blended and flexible case management services; and 5) other Medicaid programs that provide necessary medical, social, educational, psychosocial, employment, habilitation, rehabilitation and residential and legal support in accordance with the person's individualized service plan. While our analysis of the fiscal impacts associated with this regulation is still a work in progress, we anticipate that New York State providers stand to lose substantial amounts of federal Medicaid funding. For more detailed information on the negative programmatic impacts associated with this regulation, enclosed are letters sent to CMS by four State Agencies.

4. Cost-Limit for Government Providers and Financing Restrictions on Sources of Federal Share

On January 18, 2007, CMS published a proposed rule that would: 1) limit Medicaid payments to governmentally-operated providers to cost; 2) require all governmentally-operated facilities to report their costs annually; and 3) narrow the definition of a "governmentally-operated" provider to those with taxing authority or that are part of a unit of government that has such authority (which, in effect, would reduce the sources of funding that can be used as the non-federal share of Medicaid expenditures).

Recognizing that the new rules represent a significant departure from longstanding practice, Congress included a moratorium on the finalization or implementation of this rule in the supplemental appropriations for Iraq war funding. Because CMS sent the rule for publication just hours before the 1-year moratorium went into effect, providers are forced to prepare now for the rule that will take effect when the moratorium ends in May 2008. Thus, with just the 1-year of protection, the moratorium does not protect the status quo, as Congress intended.

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Impact on New York State

New York State providers could lose in excess of $550 million of federal Medicaid funding if this new rule takes effect. The losses would have particular negative consequences on the NYC Health and Hospital Corporation, services for the mentally ill, early intervention programs and New York's nationally recognized service system for the mentally retarded and developmentally disabled. This rule would reduce incentives public providers now have to keep costs below payment rates so they have excess funds to offset the costs of providing services to the indigent and uninsured. The rule would impose impossible administrative burdens on New York, such as complex, site-specific cost reports for school districts and over 1200 small group homes for persons with disabilities, and surveys of thousands of school districts and hundreds of nursing homes and hospitals to determine it they are "governmentally-operated".

5. Elimination of Medicaid Reimbursement for Graduate Medical Education

On May 23, 2007, CMS published a proposed rule that would eliminate Medicaid funding for graduate medical education (GME). Almost all state Medicaid programs have reimbursement rates that pay for a proportionate share of a teaching hospital's GME costs, as does Medicare. The proposed rule now "clarifies" that costs and payments associated with GME programs are not expenditures for medical assistance for which federal reimbursement is available.

The unjustified prohibition of these costs as Medicaid reimbursable will substantially reduce payments to the nation's teaching hospitals, which tend to be the most critical providers of hospital care for Medicaid and other indigent patients.

Impact on New York State

Eliminating Medicaid funding for GME would have a devastating impact on New York's GME programs, and would result in an estimated loss of $675 million in federal funding annually. New York has been a leader in this area, training 15 percent of the nation's physicians. CMS' action would severely penalize New York for being steadfast in its commitment to maintain the public good.

6. Rehabilitation rule

On August 13th, CMS published a rule that makes significant changes to the definition and financing of Medicaid rehabilitation services. It seeks to create a firm distinction between rehabilitation services and habilitation services, which must be paid for by other programs. However, as proposed, this delineation does not adequately account for the complex nature and scope of these necessary services. States have made tremendous progress in designing programs to address the needs of Medicaid enrollees in developing and reviewing their plan of care, when appropriate.

The proposed rule requires that a "qualified provider" deliver rehabilitation services. Qualified providers are defined as individuals, rather than programs. This is a departure from the State's current approach, which views a "qualified provider" to be a licensed agency, rather than the staff members employed by the program.

Impact on New York State

The rehabilitation rule could jeopardize up to $45 million in annual federal funding for the Early Intervention program that provides services to children under age three with developmental disabilities or delays, and for many of New York's programs for persons with mental illness, including housing-related supports and services, employment-related supports and services, services that use a team-based approach, and any program that includes another type of treatment goal, such as a social skills development goal. In the mental health and developmental disability areas alone, up to $113 million in annual federal revenues could also be jeopardized. Lastly, $44 million in annual federal Medicaid reimbursement could be jeopardized for school-based services administered through Department of Education, local school districts and nonprofit providers.

7. School Based Health Services

On September 7th, CMS issued a proposed rule that would eliminate Medicaid funding for school based administration expenditures and costs related to transportation of school-age children between and home and school. Under the proposed rule, CMS would eliminate a longstanding policy of providing federal matching payments for administrative activities when performed by school employees or contractors and for transportation services between home and school for school-aged children with an Individualized Education Program (IEP) or an Individualized Family Services Plan (IFSP) under the Individuals with Disabilities Act (IDEA).

The proposed rule would also eliminate federal reimbursement for expenditures for transportation between home and school for children with an IEP or IFSP established pursuant to IDEA. This proposal is based on the HHS Secretary's determination that transportation between home and school does not meet the definition of an optional medical transportation service and is not necessary for the proper and efficient administration of the state plan.

Impact on New York State

The proposed rule would eliminate all funding for transportation between home and school for school-aged children with an Individualized Education Program ("IEP") under IDEA. Transportation still remains available between school or home to a non-school based medical service provider, yet if the Medicaid covered medical service is being offered at school, then transportation reimbursement is not available. Additionally, federal funding remains available for the transportation of all other groups of Medicaid-covered individuals to medical service providers. It is only school-aged children receiving medical services at school whose transportation will not receive federal funding. This funding expectation violates federal regulations that require comparability in the amount, duration, and scope of services for all those who quality for Medicaid services. New York State would lose $44 million annually in transportation funding. The state does not claim administration costs.